KEYNOTE ADDRESS

Family Planning - A Priority Social and Health Action Programme for Africa and the Role of the Physician

Dr. A.A. Arkutu

Human reproduction involving the creation of another being from our own flesh and blood and through which "we find personal identity and value, make connections with ancestors and descendants" holds a central place in all cultures. Consequently fertility regulation, because it touches on the most private and intimate aspect of the life of the individual and evokes strong emotions about its moral, ethical and cultural implications at all levels, has been a subject of great sensitivity and concern from the beginning of human civilization.

Different cultures, religions and societies have taken different positions on the issues of contraception and abortion and their views have changed with time but in Sub-Saharan Africa as a region, the topic of contraception and family planning (FP) have been especially sensitive and complex. FP programmes which promote the use of safe and effective modern methods of contraception which enable individuals or couples to determine by choice, not chance, the timing, spacing and the number of their children, have not been well received as a rule.

Many reasons have been given by various groups opposed to FP to explain its low acceptance in Africa. The Slave Trade devastated Africa's population resulting in the region south of the Sahara becoming the least populated region in the world and, historians argue, the balance must be restored. Africa, the argument goes, will remain marginalized in geopolitical terms unless it can increase its population. Traditionalists and convertists believe African culture is pronatalist because it places a high value on children. Many church and religious leaders are opposed on moral grounds, fearing that contraception will loosen the chains of chastity. Doctors hesitate apparently out of concern about the risk - benefit factor while others cite the spread of HIV infection as justification for not promoting FP.

Mr. Chairman, time does not permit us to address all these issues exhaustively. I proposed therefore to concentrate on one or two aspects of the problem which I believe provide strong reasons for physicians to become more actively involved in advocating and providing FP services. I would like to begin by clearing up a common source of confusion in discussing population and FP. Population polices and programmes tend to be made by governments and emanate from considerations focusing on the interests and welfare of society as a whole. FP services, on the other hand, are motivated by respect and concern for the autonomy and well-being of the individual and has, an underlying principles, the right of the individual to decide. Population policies and programmes and FP services often reinforce each other and FP constitutes a major intervention strategy in nearly all population policies and programmes.

FP may be interpreted to mean the decision or steps taken voluntarily by a couple or individual to have the number of children they want at the time they choose, having regard to the interests and well-being of the family, and in full appreciation of the personal and social consequences of their decision. Thus defined, FP encompasses not only child spacing and family size limitation but also the prevention and appropriate management of involuntary infertility. Its scope goes beyond the preservation and regulation of fertility and includes the physical, psychological and social well-being of the individual and the family.

Social and Welfare Rationale for FP

The period between Independence in the early 1960s and the mid-1970s was one of great excitement, confidence, optimism and rising expectations in Africa. It was a period in which African governments embarked on ambitious programmes of economic and social transformation intended to promote economic growth, social justice and equity. The aim was to eradicate poverty and illiteracy, promote health and reduce the high levels of illness and mortality, especially among vulnerable groups (women and children), ensure adequate food security at national and family level and provide employment. Huge investments in education and health were made in an effort to bring services within the reach of all. It was expected that these investments would raise living standards, improve the quality of life, increase life expectancy and lead to a qualitative improvement in the human resource base that would generate sustainable development and progress.

This was also a period when Africans and others saw their continent as a modern day GARDEN OF EDEN of huge and sparsely populated land with unparalleled natural resources where gold, diamonds, oil, rubber, bauxite, copper and other valuable minerals abound. All that was required was to successfully exploit these resources for the benefit of Africans.

By the mid-1970s many African countries had recorded modest achievements in education, the provision of health services and in other fields. Countries like Tanzania had in fact achieved quite spectacular successes - up to 90% school enrolment, 95% adult literacy and a network of health facilities which brought basic services to within walking distance of 80% of the population. The economies of most countries were growing at a respectable 3 to 4% per annum.

Africa was in a confident mood. When in 1974, 156 countries sent delegates to Bucharest to discuss the interrelationship between rapid population growth and development and to devise strategies to reduce population growth, the majority of African countries saw population growth as a non-issue. African intellectuals, policy makers and planners genuinely believed that, for Africa at least, if there was disharmony between economic performance and population (numbers) then the problem was best addressed from the economics side of the equation. People, in large numbers, constituted not only the ultimate resource but also provided the motor as well as the rationale for development. Economics, not the Pill, they argued, was the best contraceptive. Meanwhile, back in the GARDEN, development policies and plans were formulated and implemented with little or no regard for the numbers of intended beneficiaries! Attempts by international donors to link population policies and programmes such as FP to development assistance were resisted and perceived as genocidal in intent, tactical diversions or blunt refusal by the rich to confront fundamental issues like the North-South relationship, distorted terms of trade and unfair commodity prices which operated against the interests of poorer countries.

Mr. Chairman, Ladies and Gentlemen, if you have lived anywhere in Africa South of the Sahara during the past ten years you cannot fail to have noticed the almost total collapse of the economies of many African countries and the catastrophic decline in living standards that has accompanied it. By 1986, Sub-Saharan Africa, with a total population of some 480 million which was growing faster than elsewhere in the world, was the world's least developed region containing 25 of the 35 Least Developed Countries in the world. As economies stagnated or actually recorded negative growth governments found it increasingly difficult to maintain existing services let alone expand them to meet the needs of fast growing populations;

urban hospitals and rural health centres and clinics built in the 1960s and 1970s have physically deteriorated and became hopelessly overcrowded, even as medicines and essential drugs all but disappeared and the quality of care sharply declined.

School enrolment and the quality of education have both declined under pressure of increased demand as governments found it impossible to construct enough classrooms, train the requisite number of teachers or provide suitable educational materials. We approach the end of the present century with less than 50% of our children in school and Africa will enter the next century with an estimated 300 million children and adults unable to read or write. Young people are compelled to move from the rural areas into already overcrowded towns and cities in search of non-existent jobs. As I left Dar-es-Salaam last Thursday, the headline on the front page of the main national newspaper proclaimed the imminent dismissal of 10,000 civil servants with another 20,000 losing their jobs next year. There was no mention of what was to happen to new University graduates or the thousands of school leavers.

Not a single Sub-Saharan African country currently produces enough food to feed its population. Lacking the resources to pay for food imports, most have to rely on food aid to tide them over. Today, Africa has become synonymous with starvation and the GARDEN OF EDEN is one in which hundreds of thousands of children and adults die every year from hunger. The FAO predicts that if present trends in food production continue, Africa would face famine and starvation on an unprecedented scale by the year 2000.

In the past six or seven years, Africans have learnt a new vocabulary under the tutelage of the IMF and the World Bank - structural adjustment, debt burden, priority social action programme, currency alignment and privatization - but otherwise not much has changed and for millions of Africans born today the future is decidedly bleak. I do not, Mr. Chairman, wish to suggest that FP will prove a panacea for all of Africans problems or that population growth is the sole reason for our current situation.

FP will not improve our overall economic performance, it will not raise GNP; FP will not eliminate mismanagement, corruption, incompetence or waste in the system, nor will it correct ill-conceived and disastrous economic policies. FP will not build more schools or hospitals, roads or houses; FP will not feed the hungry or create new jobs.

I believe however, that it is absolutely crucial for us to see FP as one of several strategies or interventions in an overall and integrated socio-economic development plan. Within such a framework, FP can be seen as enabling a country to retain a measure of control over the rate of population growth, providing valuable time to mobilise resources and develop the necessary social services infrastructure. Given the fragile economies of most of Africa, providing basic education, health care, water and sanitation, shelter, employment as well as adequate nutrition for a population that doubles every 20 to 25 years is not feasible. It is more likely that unless population growth slows down sharply and soon, living standards will continue to fall, unemployment and poverty will increase and famine and hunger will drive peasants from the rural areas into urban ghettos threatening social cohesion, national security and peace. I believe wider acceptance and practice of FP by its demographic impact could have a profound effect on Africa's chances for real and sustained development in the next century.

I know we are not economists or politicians but we are all citizens. In Africa, at least for the time being, the medical profession continues to enjoy a level of public confidence and respect not accorded to other learned professions. We are held in high esteem and what we say, especially when we speak collectively carries a lot of weight along the corridors of power. We owe it to ourselves, our fellow citizens, but especially future generations of Africans to come out strongly in support of efforts, policies and programmes to reduce the growth rate of the population and establish some harmony between the numbers of people and their reasonable aspirations in life.

Maternal Mortality and Morbidity in Africa

Custom and practice decree that the African woman begins child bearing as soon as she is biologically capable and continues until she reaches the menopause. She spends between sixteen and twenty years of her active reproductive life span bearing up to six to eight children inspite of the considerable risks to her own life and health. Complications of pregnancy and childbirth claim the lives of an estimated 150,000 African women annually. The time risk of dying from a pregnancy-related cause for an African woman is about 1 in 15, over 100 times the risk to which her European or North American sister is exposed. The Maternal Mortality Ratio which relates the number of deaths to live births, averages between 400 and 600 per 100,000 live births and in parts of Africa may be as high as 1,000 per 100,000.

High and disturbing as these figures may appear, there is a general feeling that they do not tell the whole story as many deaths go unreported especially in communities accustomed to high levels of general mortality. Morbidity rates, though difficult to measure, are extremely high and conditions such as vesico-vaginal fistulae can be so devastating for the personal, marital and social life of women that many survivors feel cheated out of death! Translated into terms of social experience, these statistics mean that in some rural communities half the cohort of women who start child bearing about the same time would be dead before they reach the end of their reproductive lives and most African families have experienced the loss of a young mother in the prime of life. So universal is this experience and expectation that in some communities, for example Tanzania, a woman going to hospital to have a baby may warn her children "I am going to sea to bring a new baby. The journey is long, rough and dangerous. I may not come back!" Everyone agrees that pregnancy is not a disease. But then how do we as Doctors reconcile the ambiguity which makes a state of well being such a close ally, a bed-fellow of death.

We are all familiar with the immediate and clinical causes of death (haemorrhage, sepsis, hypertensive disorders of pregnancy, obstructed labour and abortion). We all know from the mountain of evidence that has been accumulated from all over the world that situations in which women have pregnancies too early, or too late and pregnancies too many or too close together, especially under conditions of limited or no access to adequate reproductive health care, gravely imperil their lives. We can deduce that such situations arise because of the poor social conditions of women, their poor education, lack of power to make decisions regarding their own fertility and lack of access to the information and services which would enable them to control their fertility. We know from the evidence of numerous induced abortions reaching our hospital wards how far many women are prepared to go to rid themselves of unwanted pregnancies, mindful of the health and legal risks involved.

Our collective experience as health care providers in Africa compels us to admit that despite expansions in health care facilities, significant increases in the number of trained and skilled personnel, improvements in treatment regimes for obstetric complications, access to a wide range of sophisticated diagnostic tools and techniques, not to mention an arsenal of powerful new drugs, women continue to die in their hundreds and thousands every year. This situation, Mr. Chairman, is an affront to the dignity of women and poses a serious challenge to our conscience as physicians and is an indictment of the profession.

There is today, a global consensus and determination that everything possible must be done to stop the carnage and to reduce maternal mortality by at least 50% by the year 2000. We have the technology, the means and the resources to achieve that goal.

It is against this background that physicians and other health care providers should assess the contribution that FP can make and evaluate their own responsibility and roles in ensuring the availability and quality of FP services. I hope no one here needs persuasion that FP does save lives and promotes the health of

mothers and children. WHO calculates that FP alone could save the lives of two million infants and children under the age of five and reduce maternal mortality by 40%.

The health benefits of FP are now universally recognised and provide a rationale, and sometimes, the sole justification, for government support for FP programmes and services in almost all African countries today. I suspect, Mr. Chairman, that similar considerations must have figured in your governments recent and most welcome decision to expand child spacing services.

There is no doubt that fertility regulation poses some of the most vexing moral and ethical issues that confront our profession. Depending on his or her cultural background, religious persuasion or social attitudes, a physician may not fully subscribe to the tenets of the Teheran Declaration (1968), the statement signed by the representatives of 136 governments in Bucharest in 1974, its reaffirmation in Mexico ten years later, or the Convention on the Elimination of All Forms of Discrimination Against Women, all of which underscored the basic and natural rights of individuals to decide and their social rights of access to the means to regulate their fertility and governments' responsibility to make appropriate services available. As physicians however, we all do subscribe to one moral and ethical imperative which is respect for the sanctity of human life, its preservation, protection and promotion which overrides other considerations. This imperative should define our roles and responsibilities as health professionals.

The general attitude of the medical profession towards the delivery of FP in many countries to date can be described in one word, NEGATIVE. In most countries doctors have been surprisingly lukewarm in their support for FP and it is unusual to find a strong advocate for FP within the ranks of the profession. Very few doctors are actually involved in the delivery of FP services which has largely defaulted to lower cadres of the health care profession and trained but non-medical volunteers. Even in countries like England and Wales, doctors provide less than 15% of FP services. Instead of providing leadership and technical support the majority of doctors simply ignore the issue, citing lack of awareness or appreciation of the nature of the problem, pressure of work from other more urgent responsibilities and concern about the potential risks and dangers of contraceptive use. Many people find this ambivalent position of the profession incomprehensible. If the doctor in charge of obstetrics and gynaecology is unaware, if the doctor in charge of the district hospital is unaware and if the DMO/RMO is unaware that many women are dying from preventable pregnancies-related causes then, who, in heaven's name, is aware? And if aware, can it truly be that the doctor is too busy to provide or supervise the delivery of services that demonstrably can save so many lives? Or, is it that priorities are slightly out of focus?

It is indeed a solemn responsibility, in dealing with the lives of others, for the doctor to balance carefully the potential risks of any intended action against its likely benefits. This is something we do everyday, almost sub-consciously. When this principle is applied to FP in the context of Africa, the balance is overwhelmingly in favour of the use of contraceptives to protect women from unwanted pregnancies. In terms of its potential contribution to saving women's lives, the combined hormonal oral contraceptive (The Pill), introduced by Pincus and Rock nearly 30 years ago is as important as the discovery by the Hungarian Obstetrician, Ignaz Semmelweiss of the source of the contagion that killed so many women soon after childbirth 100 years ago, or, the advent of penicillin and other antibiotics some 50 years ago. The Pill, and today's low dose formulation especially, is as safe as the ubiquitous aspirin or chloroquine and is probably the first therapy in the history of medicine that can actually prevent certain cancers and extend an individual's expectation of life. Over 30 million women worldwide rely on the Pill to protect themselves against unwanted pregnancies. In my view, that represents a significant vote of confidence in the Pill by women whose lives are on the line. Carefully evaluated scientific and epidemiological data confirm the effectiveness and relative safety of the Pill to the extent that even the US Food and Drugs Administration has had to revise its guidelines on oral contraceptive use, eliminating the limitations on women aged over 35 years provided they do not smoke.

The Hypocratic Oath enjoins us to be vigilant and not to administer anything that is injurious to the health of the patient. I believe the corollary to be also true that we must not unjustifiably withhold any information or intervention that may protect the life or promote the health of the client. The benefits of FP far outweigh the potential risk of side effects and, in Africa as we all know only too well, such risks palê into insignificance against the threat to life and health from a single unplanned, unwanted pregnancy. We must ask ourselves if we have the right to withhold from women FP information and services for the need to avoid unwanted pregnancies.

In my opinion, Mr. Chairman, FP constitutes a priority programme for social and health reasons for which doctors have a major responsibility. This responsibility requires us to be consistent advocates for FP because of its proven life-saving and other health benefits. Just as we are required to report an outbreak of cholera or cerebral meningitis, we have a duty to inform the authorities and the public at large that pregnancies too early, too late, and pregnancies too many and too close together kill many women and children.

As technical experts we have a duty to inform ourselves of recent progress and advances in FP service delivery and research in order to provide policy guidelines and technical support. We have to become actively involved in the design and implementation of FP programmes in order to ensure that FP services are not only provided on an equal basis with other PHC interventions, but also that acceptable standards of care are maintained for the benefit of clients.

We have a duty to safeguard the health of women by ensuring the availability of different types of contraceptives realizing that there is no ideal contraceptive that is appropriate for all women, or even the same women at different phases in her life. In this regard, we must also publicise and promote male contraceptives and voluntary surgical contraception for those couples who have completed their desired family size.

As doctors, we must reject as morally repugnant the notion that the spread of HIV infection and the disease AIDS renders FP services redundant in Africa. The spread of HIV highlights the need to intensify FP information and education and to continue to strengthen FP services while supporting global efforts to control the spread of the disease and find a cure.

Mr. Chairman, it was timely and courageous for the Medical Association of Malawi to organize a conference on the subject of fertility regulation. I would like to congratulate the Association on both counts. I hope that doctors practising in Malawi will begin to view FP in a new light and appreciate the need for the profession to become actively involved. I may warn you that the going will not be easy. There will be doubts and open resistance. Daunting problems of programming, logistics, resources, etc. will soon appear. But I believe the same courage you have shown in organizing this seminar at this time will enable you to cope with problems as they arise.

You have my sincere good wishes for success.

Dr. Arkutu
UNFPA Representative
Tanzania